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Governor

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State of Wisconsin
Department of Health Services

DIVISION OF PUBLIC HEALTH

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December 13, 2021

(Via E-Mail and Certified US Mail)

[REDACTED]
[REDACTED]
[REDACTED]

RE: Letter of Warning to [REDACTED]

Dear Mr. [REDACTED]:

The Department of Health Services (Department), Emergency Medical Services (EMS) Section, hereby issues a letter of warning to you, [REDACTED], for failure to follow the patient care protocols of the emergency medical service provider with which you were serving while performing patient care, as required by Wis. Admin. Code § DHS 110.13(3).

Factual Basis for the Department's Action

On April 12, 2021, the Department received a complaint regarding patient care you participated in on October 31, 2019, while functioning as a member of the [REDACTED].

The [REDACTED] maintains patient care protocols as part of its operational plan in accordance with Wis. Admin. Code § DHS 110.35(2)(a). On May 20, 2021, the Department requested a copy of the [REDACTED] patient care protocols in place on October 31, 2019. The [REDACTED] provided the Department a copy of these protocols on June 21, 2021.

The patient care described in the patient care report for the incident on October 31, 2019, deviates from the [REDACTED]'s protocols for Routine Medical Care for all Patients and the Narcotic/Opiate Overdose. The [REDACTED]'s Routine Medical Care for all Patients Guidelines requires emergency medical services practitioners to assure adequate respiratory exchange and to ventilate with supplemental oxygen in those patients with absent or inadequate respirations. The [REDACTED]'s Narcotic/Opiate Overdose Guideline states:

There is no evidence of naloxone improving the chance of ROSC when a patient is in cardiac arrest due to a narcotic /opiate overdose. Focus should be on standard CPR / ACLS with good CPR and mechanical ventilation rather than attempts with naloxone.

The patient care report states emergency medical services arrived to find the patient with agonal respirations. Despite the immediate recognition of agonal respirations, the patient care report

documents that naloxone was administered before assessing for pulses or beginning resuscitation efforts.

Documentation on the patient care report does not follow the standard established by the [REDACTED]'s Narrative Documentation Guideline. The [REDACTED]'s Narrative Documentation Guideline states emergency medical practitioners should document signs and symptoms, treatments not otherwise mentioned in the record, responses to treatment, and reassessments done besides the initial assessment. The patient care report for the incident does not include pertinent patient care information such as interpretation of the patient's cardiac rhythm, intravenous access, reassessment findings, or response to medication administration.

Legal Authority for Department Action

Under Wis. Admin Code § DHS 110.55,

The department may issue a warning letter to a licensee, permit holder, or certificate holder if the department finds that the person has committed a minor, first-time violation of a requirement of this chapter or ch. 256, Stats., or a minor, first-time violation identified in s. DHS 110.54. The department shall retain a copy of the warning letter in the person's file and may consider it when determining what enforcement action is appropriate if the person commits subsequent violations...

Wis. Admin. Code § DHS 110.13(3) states,

An emergency medical service professional shall follow the patient care protocols of the emergency medical service provider with which the EMS professional is serving while performing patient care, regardless whether the EMS professional is licensed at a practice level higher than that of the provider.

Department Action

Based on the records submitted, it has been determined that you failed to follow the patient care protocols of the emergency medical service provider with which the EMS professional is serving while performing patient care, in accordance with Wis. Admin. Code 110.

In accordance with Wis. Admin. Code § DHS 110.55, the Department will post a copy or summary of the letter of warning, which does not identify the recipient of the letter, on the Department's EMS website, will retain a copy of this letter of warning in your file, and may consider it in determining what further enforcement action may be appropriate if subsequent violations occur.

December 13, 2021

Page 3 of 3

Pursuant to Wis. Admin. Code § DHS 110.55, the Department's issuance of this letter of warning is a final decision of the Department and is not subject to an administrative hearing.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeff Phillips". The signature is written in a cursive, flowing style.

Jeff Phillips
Director
Office of Preparedness and Emergency Health Care
Wisconsin Department of Health Services